Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BRECKENRIDGE SURGERY CENTER
3201 EAST GEORGE BUSH FWY SUITE 100
RICHARDSON TX 75082

Respondent Name

TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-11-3212-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "ASC Fee Guidelines."

Amount in Dispute: $414.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier reimbursed the Provider $206.24 and $1,556.09, respectively, under the ASC Fee Guideline.

Response Submitted by: Travelers, 1501 S. Mopac Expressway, Suite A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2011	ASC Services for code 11012-SG	$253.81	$23.78
	ASC Services for code 14040-SG	$160.92	$160.92
TOTAL		$414.73	$184.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated March 14, 2011

- 9TXN, W1-Workers compensation fee schedule adjustment. Payment based on Medicare payment policy pertaining to ASC multiple procedure guidelines, CFR Title 42, Section 416.172(e)(2).
- 9TXN, W1-Workers compensation fee schedule adjustment. Payment based on CMS ASC facility payment guidelines.

Explanation of benefits dated May 6, 2011

- Z013, W1 -Workers compensation state fee schedule adjustment. This bill has been processed correctly per the state fee schedule.

Issues

1. Is the requestor entitled to additional reimbursement for code 11012-SG?
2. Is the requestor entitled to additional reimbursement for code 14040-SG?

Findings

1. The respondent paid the disputed service based upon reason codes "Z013, W1 -Workers compensation state fee schedule adjustment. This bill has been processed correctly per the state fee schedule"; "9TXN, W1-Workers compensation fee schedule adjustment. Payment based on Medicare payment policy pertaining to ASC multiple procedure guidelines, CFR Title 42, Section 416.172(e)(2)"; and "9TXN, W1-Workers compensation fee schedule adjustment. Payment based on CMS ASC facility payment guidelines".

   28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   HCPCS code 11012 is defined as "Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone"

   The MAR for HCPCS code 11012-SG is $460.05 ($195.77 X 235%). HCPCS code 111012 is subject to multiple procedure discounting; therefore, $460.05 X 50% = $230.02. The respondent paid $206.24. The difference between the MAR and amount paid is $23.78; this amount is recommended for additional reimbursement.

2. HCPCS code 14040 is defined as "Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less."

   The MAR for HCPCS code 14040 is $1556.09 ($662.17 X 235%). The respondent paid $1395.17. The difference between the MAR and amount paid is $160.92; this amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $184.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $184.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		5/11/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.